ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Medical Centers in Minneapolis and St. Cloud, Minnesota
February 29, 2016

1. Summary Why the Investigation Was Initiated

This investigation was conducted based on information reported in the news media insinuating that the VA Medical Center (VAMC) Minneapolis had manipulated the date in which an appointment was canceled. The media reported that the VA computer system showed that the veteran called to cancel his appointment on the date in question, but in fact, the veteran had died prior to the date indicated in the VA system.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The mother of the deceased veteran, schedulers at the VAMC St. Cloud and the VAMC Minneapolis specialty clinics, and Information Technology staff from AudioCARE were interviewed.
- **Records Reviewed:**
  - Review of records from AudioCARE, an automated scheduling system
  - Raw email data within the Veterans Health Information Systems and Technology Architecture (VistA) from appointment schedulers
  - Individual email archives of appointment schedulers

3. Summary of the Evidence Obtained From the Investigation

- In late 2012, the veteran died as a result of a seizure disorder. At the time of his death, the veteran was receiving treatment from a specialty clinic at the VAMC Minneapolis. The veteran was last seen at the clinic in June and was considered to be stable. The veteran was instructed by the VA specialist to contact the clinic should he have another episode or have any other problems with his prescribed medication.

- In September 2012, the veteran was taken by his family members to a nearby private hospital in St. Cloud, MN, for an emergency room visit. Two days later, notes reveal that a licensed practical nurse (LPN) at VAMC St. Cloud attempted to telephone the veteran in order to arrange a follow-up appointment related to his prior emergency room visit at the non-VA facility. The LPN advised us that she did not recall the specific call; however, she explained that she automatically received an email within VistA. These emails identified all veterans discharged from the local St. Cloud private hospital. If these veterans were under the care of VAMC St. Cloud, VA personnel would contact them to see how there were doing and establish whether follow-up appointments were needed. One day after the LPN's call, the veteran returned the call to the VA and scheduled an appointment. VA uploaded the report from the private hospital in VistA

2 days before the appointment. The physician's plan from the non-VA encounter included the following, "Send a copy to his doctors at the VA Medical Center for follow-up and possible level and medicine adjustment as needed."

- The veteran arrived at VAMC St. Cloud for his scheduled appointment; however, his appointment was canceled because his physician was unavailable. The status of this appointment was entered as "Canceled By Patient" though it also included the cancel remark "cl cx re 1004 to 1010" (shorthand for canceled by clinic). We interviewed the scheduler who made these entries. She had no specific recollection of the appointment. Upon reviewing the document, she concluded that she had mis-keyed "Canceled By Patient" and that the entry should have been "Canceled By Clinic" as noted in the remarks section. The appointment was rescheduled for 6 days later. At this appointment with a VA physician (general practitioner), the veteran was advised to schedule another appointment at a specialty clinic in Minneapolis.

- Two days later, the veteran contacted a nurse at the VAMC Minneapolis specialty clinic. The veteran advised the nurse of the recent episode that caused him to seek care at the non-VA emergency room, and requested an appointment. We interviewed the nurse who made this entry but he had no specific recollection of the event. Upon reviewing his patient note, he surmised that he would have forwarded it to the specialist and noted that the specialist had indeed electronically signed the document acknowledging receipt. Seven days later, a VA scheduler contacted the veteran to schedule the appointment. The record reflects that the veteran requested to be seen in 2 weeks; however, he was scheduled for an appointment almost 2 months later. We interviewed the scheduler regarding this event. He had no specific recollection of his actions. Upon reviewing his entry within the Computerized Patient Record System (CPRS), he opined that he had scheduled the next available appointment as would normally be his practice. VA records reviewed thus far by the VA OIG do not reflect any information indicating that there was a medical triage of the veteran's condition. The scheduler stated that he could not recall the specialist ever instructing him to schedule based upon medical priority. The VA OIG did not interview the specialist. The veteran died on or about 3 weeks before the appointment at approximately 5:55 p.m.

- As reported in the media, about 4 days after the veteran's death, another VA scheduler within the specialty clinic modified the scheduled appointment to reflect a cancellation at the request of the patient. An interview of the scheduler who made this entry provided three scenarios by which an existing appointment could be canceled. First, a patient can call the clinic directly and request the change. Second, the patient can call the VA Call Center to request the change and the Call Center would then, in turn, forward the request to the appropriate clinic. This notification can be via a telephone call to the clinic or by email notification within VistA. The third mechanism is the patient contacting an automated system called AudioCARE. Through AudioCARE, patients can request a change by entering the appropriate numeric entry on their phone at the prompting of the AudioCARE program. This request is then automatically communicated via email within VistA to an email group of schedulers at the respective VAMC.

- The VA OIG contacted a member of the Information Technology staff from AudioCARE who related that the VAMC Minneapolis AudioCARE system was set up to go live in 2011 to allow patients to call in to hear upcoming appointments 24/7, and to confirm, request to cancel, or reschedule their appointments. This feature was standardized throughout Veterans Integrated Service Network 23. With this feature turned on, a daily report is configured to transmit the information on the patients requesting to cancel or reschedule their appointments to the designated medical center staff for action. This report is set up to automatically transmit the requests from patients who called the system the previous day. This automatic transmittal is done via email daily at about 6:00 a.m. This transmittal email includes the patient's name, patient identification (Social Security number), the appointment date and time that the patient wanted to cancel, the time the patient called, and the telephone number from which the call was received. The transmittal email is sent via the VistA system. AudioCARE itself does not maintain an archive of the telephone calls or of the subsequent emails that are automatically generated. Records are not maintained in AudioCARE beyond a period of 30 to 90 days as determined by the facility.

- The scheduler who canceled the veteran's appointment on what appeared to be 4 days after his death reported that it was her practice to delete all such communication after the scheduled activity occurred and that she was not in the practice of keeping such email correspondence as she understood there to be a requirement under VA privacy rules to not store such data. Initial efforts by the VA OIG to capture the email activity of the scheduler for the relevant time period identified raw data within VistA that was associated to an email sent via AudioCARE 3 days prior to the date the appointment appeared to have been canceled. The data in raw form are difficult to read but do document the date and time that the veteran called AudioCARE and the telephone number from which the call was made. The data also identified that 16 other VA schedulers received the same automated AudioCARE email. These schedulers were instructed to review their email archive in an effort to locate the original transmission. Three schedulers subsequently located the original AudioCARE email.

- In its original form, the email was easier to read and also included information captured by the AudioCARE system. The email showed the veteran called AudioCARE from his cell phone on the date of his death at 11:17 a.m. This notification was subsequently transmitted via AudioCARE to the scheduler email group the next day at 6:01 a.m. At 10:11 a.m. that day, the scheduler who ultimately canceled the veteran's appointment transmitted a response to the group that she would take care of the request. The scheduler was absent on annual leave, and it was not until 10:49 a.m. 4 days after the veteran's death that she entered a note within VistA that she had canceled the patient's appointment, as requested, and tentatively scheduled him for the next available appointment, which was about 3 weeks later. At the time the scheduler entered this note, she was unaware that the veteran had died 4 days earlier.

- The veteran's mother was interviewed by VA OIG agents on September 29, 2014; she confirmed that she had spoken with her son earlier on the date of his death and that he had died unexpectedly that day at around 5:00 p.m. She had no knowledge about whether or not he had called to cancel his VA appointment that day.

- The investigation confirmed the veteran's cell phone number as the number from which the call was made canceling the appointment.

4. Conclusion

The allegations were not substantiated.

The OIG sent the Memorandum for Record to VA's Office of Accountability Review on June 4, 2015.

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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.